

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

NOV 15 1937

MISSOURI STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Homer G Phillips Hospital

791

35698

Do not use this space.

1. PLACE OF DEATH

(a) County..... Registration District No.....
(b) Township..... Primary Registration District No.....
(c) City..... Saint Louis (d) Street No. 2601 N Whittier Registered No. 9275
(e) Length of residence in city or town where death occurred 33 yrs. mos. ds. (f) How long in U.S., if of foreign birth? yrs. mos. ds.
(If death occurred in Hospital or Institution, write its name instead of street and number)

2. PRINT FULL NAME

Ida Smith

(a) Residence, No. 2036 a O'Fallon St. 21 (If nonresident, give city or town and State)
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F 4. COLOR OR RACE C 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) married
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF unknown
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Jan. 1, 1885
7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
52 8 27
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Housework
9. Industry or business in which work was done, as saw mill, bank, etc. at home
10. Date deceased last worked at this occupation (month and year)
11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) Tennessee (STATE OR COUNTRY)

13. NAME Aaron Shelton

14. BIRTHPLACE (CITY OR TOWN) Tennessee (STATE OR COUNTRY)

15. MAIDEN NAME Nancy Watkins

16. BIRTHPLACE (CITY OR TOWN) Tennessee (STATE OR COUNTRY)

17. INFORMANT Evelyn Hilliard (ADDRESS) 2601 N Whittier

18. BURIAL, CREMATION, OR REMOVAL PLACE Father Dicksons DATE 10/10/37

19. FUNERAL DIRECTOR E. L. Garne (ADDRESS) 2829 Washington Ave

20. OCT 4 1937 Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Sept. 28 19 37

22. I HEREBY CERTIFY, That I attended deceased from Sept. 24 19 37 to Sept. 28 19 37
I last saw her alive on Sept. 28 19 37 Death is said to have occurred on the date stated above, at 12:15 p.m.
The principal cause of death and related causes of importance were as follows:

Septicemia staphylococcus generalized Cause unknown
Date of onset 9/24/37

Other contributory causes of importance: 36

Name of operation..... Date of.....
What test confirmed diagnosis? clinical Was there an autopsy? yes

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide?..... Date of injury..... 19.....
Where did injury occur? (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury.....
Nature of injury.....

24. Was disease or injury in any way related to occupation of deceased? If so, specify
(Signed) A. L. Lewis, M. D. 2601 N Whittier
(Address)

STATEMENT BY LICENSED EMBALMER

I, Arthur L. Hilliard, Licensed Embalmer No. 3389

hereby certify that the body recorded on the reverse side of this certificate was embalmed by me

L. E.

No. _____ or by _____, Registered Apprentice No. _____
working under my personal supervision.

Signed

Arthur L. Hilliard

Licensed Embalmer No. 3389

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)